DOCUMENT RESUME

ED 317 935 CG 022 454

AUTHOR White-Means, Shelley I.; Thornton, Michael J.
TITLE Labor Market and Home Care Choices of Employed Ethnic Caregivers.
PUB DATE Nov 89
NOTE 19p.; Paper presented at the Annual Meeting of the Gerontological Society (42nd, Minneapolis, MN, November 17-21, 1989). Partial financial support received from Avron B. and Robert F. Fogelman Academic Excellence Fund.
PUB TYPE Reports - Research/Technical (143) -- Speeches/Conference Papers (150)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS Comparative Analysis; Cultural Differences; Decision Making; *Employment; *Ethnicity; *Family Caregivers; *Frail Elderly; *Role Conflict; *Time Management

ABSTRACT

The presence of family caregivers in their homes has mitigated the need for the elderly to choose between reducing health services (and thus health) to levels that they can afford or going into serious debt to maintain health. However, caregivers must balance their role of health producer in the home with their role of income producer in the labor market. This study used data from the National Long Term Care and National Survey of Informal Caregivers (1982) to link and examine two decisions of employed informal caregivers (the allocation of time to care production and to the labor market) among German-, Irish-, English- and African-Americans. The results revealed that among ethnic caregivers, production factors, access to financial resources, and personal characteristics of caregivers were significant determinants of decisions concerning caregiving and labor hours. It was found that the lower the health status of the elderly care receiver and/or the worse the health of the caregiver, the more likely the caregiver was to increase caregiving hours and reduce labor market hours. White ethnic groups were found to exhibit heterogeneous patterns of caregiving. (Author/TE)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED317935

LABOR MARKET AND HOME CARE CHOICES OF EMPLOYED ETHNIC CAREGIVERS

Shelley I. White-Means, Ph.D.
Department of Economics
Memphis State University
Memphis, Tennessee 38152

Michael J. Thornton, Ph.D.
Department of Afro-American Studies
University of Wisconsin-Madison
Madison, Wisconsin 53706

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☑ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

Shelley I. White-Means

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

Paper prepared for the 42nd Annual Meeting of The Gerontological Association (1989), Minneapolis, Minnesota. The authors acknowledge the partial financial support of the Avron B. and Robert F. Fogelman Academic Excellence Fund.

CG 022 454

BEST COPY AVAILABLE

LABOR MARKET AND HOME CARE CHOICES OF EMPLOYED ETHNIC CAREGIVERS

Abstract

Family members and friends of the elderly "produce" medical care services in the homes of the elderly. The presence and access to family caregivers have mitigated the need for elderly to choose between reducing health services (and thus health) to levels that they can afford or going into serious debt to maintain health. However, caregivers must balance their role of health producer in the home with their role of income producer in the labor market.

This paper systematically links and examines two decisions of employed informal caregivers, the allocation of time to care production and the labor market. The main contribution of the paper is its evaluation of the influence of ethnicity on the family's decisions about providing health care to meet the impending needs of an elderly family member or friend. Caregiving production factors, financial resources and personal characteristics of the informal care providers influence both caregiving hours and the labor market decisions. Furthermore, there are significant differences among German-, Irish-, English-, and Afro-Americans in their decision to provide informal care. The paper concludes with a brief discussion of both policy and research implications of this analysis.

LABOR MARKET AND HOME CARE CHOICES OF EMPLOYED ETHNIC CAREGIVERS

Demographic trends in the 1980s reflect the contribution of sophisticated medical technology to the longevity of life among Americans. However, the financing of medical care services, particularly for the elderly, did not witness a similar rate of growth during this period. Indeed, financing options have decreased for many elderly. Family caregivers have mitigated the need for elderly to choose between reducing health services use (and thus health) to levels that they can afford or going into serious debt to maintain health. Family members and friends provide another option by "producing" medical care services in the homes of the elderly.

Prior to the development of industrial organizations, such as nursing homes and hospitals, all medical care was provided in the home. Family norms of responsibility dictated these activities. During the 1960s and 1970s, care of the elderly became the shared responsibility of families and the government, with the latter bearing a disproportionate share (Shanas, 1979). Recently, the balance of sharing has been reapportioned and families have more responsibility. Simultaneously with this reapportioning was the growth and prevalence of dual career households. Thus, some family caregivers are faced with simultaneous responsibilities of labor market employment and caregiving activities.

The ultimate decisions of the family caregiver may be influenced strongly by the caregiver's desires for financial resources for present and future expenditures (Muurinen (1986) and Pauly (1989)), as well as the culture of the particular family, i.e., the family's ethnic tradition (Jackson (1989) and Gibson (1989)). While the unique role of culture in affecting caregivers' decisions has pervaded recent gerontological literature, it is supported by only limited empirical verification (White-Means and Thornton (1989) and McCallum and Shadbolt (1989). Similarly, only one recent study provides empirical confirmation of the determinants of the labor market decisions of caregivers (Muurinen 1986).

Most studies of the labor market activities of caregivers provide documentation of

whether caregivers quit their jobs or not, yet don't examine the factors that precipitate that decision. For example, using national data, Stone et al. (1986) report that 8.9 percent of the nation's caregivers withdrew from the labor market due to caregiving responsibilities. These caregivers included both spouses and adult children of the impaired elderly (Cantor 1983). Only one study of caregivers of hospice patients (Muurinen 1986) identifies the factors that lead care providers to quit their jobs. Muurinen (1986) found that income, sex, age and the relationship to the dying patient significantly influenced the employment decision. Older, female caregivers with low income and a dying spouse are more likely to quit their jobs.

Both Jackson (1989) and Gibson (1989) emphasize the need to empirically isolate the socio-demographic determinants of family decisions from the cultural and ethnic influences on behavior. Members of ethnic subgroups have developed traditions of "mutual aid" within families and communities (Mindel, Haberstein, and Wright 1988). Thus, the obligations and responsibilities assumed by members of particular ethnic groups may serve as an intervening influence on the association between socio-demographic factors and family decisions. For example, McCallum and Shadbolt (1989) have found that ethnic groups differ in the composition of their informal networks. White-Means and Thornton (1989) have found that ethnic caregivers differ in their decisions about leisure. They found that both English- and Afro-American caregivers allocate a significant number of hours to informal caregiving and are able to accomplish this because they significantly reduce their leisure time. German- and Irish-Americans do not reduce their leisure due to caregiving responsibilities.

The current research literature has not examined the labor market decisions of ethnic caregivers. This paper systematically links and examines two decisions of employed informal caregivers, the allocation of time to care production and the labor market. The main contribution of the paper is its evaluation of the influence of ethnicity on the family's decisions about providing health care to meet the impending needs of an elderly family member or friend. The paper concludes with a brief discussion of both policy and research implications of this

analysis.

ANALYTICAL FRAMEWORK

The empirical analysis is based on a theoretical model presented in White-Means and Thornton (1989). The model assumes that ethnic caregivers provide family care because they (in addition to the elderly relative or friend) derive utility/satisfaction from this behavior. If time is allocated to care provision, it is not available for other utility or income generating activities, such as leisure or labor market activities.

The empirical and theoretical models look specifically at the determinants of caregiving and the reduction in labor market hours. According to the theoretical model, these two time uses are influenced by the income of the caregiver, the financial resources of the elderly care recipient (eg., access to Medicaid and/or other health insurance), the informal support network of the caregiver, as well as socio-demographic and other personal characteristics of the informal care providers.

DATA AND VARIABLE MEASUREMENT

The data used in this study are from the National Long-Term Care and National Survey of Informal Caregivers, 1982. The National Opinion Research Center at the University of Chicago collected a nationally representative sample of 1,924 caregivers of impaired, Medicare-enrolled elderly for the U.S. Department of Health and Human Services/Health Care Financing Administration. These data are particularly valuable for the purposes of this study because informal caregivers provided information about their ethnic origin. Specifically, they were asked the question, "What is your ethnic origin or descent?" Their survey responses include a total of 17 ethnic classifications. The most frequently cited ethnic origins/descent were Irish, German,

English and Afro-American. These four ethnic populations compose 48 percent of the surveyed respondents and are the focus of the research in this study. Furthermore, the analysis sample only includes ethnic caregivers who were employed when they first began to provide informal care to the impaired elderly.

Table 1 lists definitions of all the independent variables in the model. The two dependent variables in the model are caregiving hours and labor market hours reduction. Caregiving hours, a continuous variable, reflects the respondents' answer to the question, "Thinking about all the things that you do for the (SAMPLE PERSON) because of (his/her) disability, about how many extra hours do you spend helping (him/her) on the average day?" Labor market hours reduction is measured by a dichotomous variable that equals one if the caregiver either left the labor market, reduced labor market hours or took time off without pay because of caregiving responsibilities.

A semi-log specification of the caregiving hours regression equation provides the best fit for this analysis. Since the dependent variable in the labor market hours reduction analysis is categorical, a limited dependent variable regression procedure is preferred. Ordinary least squares estimation is inappropriate and violates assumptions of normality. Consequently, a logistic regression procedure has been used.

REGRESSION RESULTS

Table 2 lists two regression models. Model I presents the regression results for the caregiving hours and labor hours reduction equations when there are no ethnic distinctions among caregivers. Model II reflects estimates for these regression equations when three ethnic dummy variables are added.

According to Model I, caregiving production factors, financial resources and personal characteristics of the informal care providers influence both caregiving hours and the labor

market decisions. However, a unique subset of variables significantly influences each decision. Furthermore, these factors don't have analogous effects on the two decisions.

Among production factors, activities of daily living, an available substitute, and the caregiver's health status and the presence of children significantly influence the hours of informal care and the employment decision. Specifically, as the elderly care recipient has more limits in instrumental activities of daily living, caregiving hours increase with no significant effect on the employment decision. On the other hand, limits in activities of daily living increase both informal care hours and employment hours are affected. With greater activity of daily living limits, caregiving hours increase as does the probability of reduced time spent in the labor market.

Likewise, if a substitute is available, each caregiver spends fewer hours providing care and is also less likely to change the number of hours allocated to the labor market. Significant differences in caregiving hours are observed when comparing caregivers with perceived poor health are compared to those with perceived excellent health. The former provide significantly more care hours. In contrast, caregivers who do not view themselves in excellent health are more likely to reduce labor market hours. The presence of children in the household significantly increases the probability that the informal care provider will reduce labor hours.

Among financial factors, both the caregiver's income and the elderly's insurance coverage are statistically significant. While, increases in income significantly decrease care hours, the elderly's health insurance coverage through Medicaid makes the informal care provider significantly more likely to reduce labor market hours.

Married caregivers provide less hours of care, yet are also more likely to reduce labor market hours. While caregivers who live with the elderly provide less care hours, they are also less likely to change their labor market time allocation. The finding that men are less likely to leave the labor market is consistent with previous research.

Model II includes ethnic dummy variables in the regression results for the model. While

the signs and results are generally consistent with the previous model, there are several important differences in the caregiving hours regression: the results for marital status and family income (no longer significant) and the results for IADl and children (now significant). Model II indicates that ethnicity significantly influences the number of hours spent in caregiving and insignificantly influences the employment decision. Two forms of statistical evidence suggest this role for ethnicity. First, the three ethnic dummy variables are each significant in the caregiving hours equation. None are significant in the employment hours reduction regression. Second, an F test of the significance of including the three ethnic variables in the caregiving regression is statistically significant at the 0.01 level ($F = 4.85$). On the other hand, the X^2 test of the empirical significance of including ethnic dummy variables in the labor reduction equation indicates that these variables (as a group) are statistically insignificant ($X^2 = 1.29$).

Two recent research papers, Jackson (1989) and Gibson (1989) introduce the hypothesis that understanding the role of ethnicity as an influence on the lives of the elderly and their caregivers requires considering ethnicity as more than just a dummy variable (Model II above). They suggest that analysis of ethnicity should be based on samples that are stratified according to this population characteristic. Unfortunately, our stratified samples are too small to perform the suggested empirical analysis. In an effort to partially glean insight on the hypothesis of Jackson (1989) and Gibson (1989), Table 3 presents data on mean caregiving hours of the four ethnic subgroups according to selected production, financial and personal characteristics.

The regression analysis indicated that there were significant differences among ethnic groups in caregiving hours. The means data reported in Table 3 show that mean hours of care per day range from 2.45 (Germans) to 4.20 (Afro-Americans). In the mid-range are English and Irish with 2.85 and 2.94 hours, respectively.

According to Table 2, Model II, living with the elderly care recipient, poor health status and having a substitute were each significant determinants of care hours. The stratified analysis suggests that these factors need not influence the decisions of each ethnic group in a similar

manner. For each ethnic group (except English) informal care providers who live with the elderly tend to provide less hours of care (on average) than those who do not live with the elderly. Additionally, poor health status leads each ethnic group to provide more care hours on average; the exceptional case is the Irish ethnic for whom average hours are the same whether health is poor or not. Furthermore, when we look at the role of the substitute, the general tendency of three of the ethnic groups (Germans, Irish and English) is consistent with the results of the analysis in which the sample is not stratified. For these groups, if a substitute is available, less hours of care are provided. The average hours of care for Afro-Americans is higher when a substitute is available.

While gender was not a significant determinant of caregiving hours in the combined models (Table 2), a stratification of mean care hours according to sex and ethnicity (Table 3) is quite revealing. For each ethnic group, there are differences in mean care hours between men and women. However, for Irish only, men average more care hours than women. Also striking is the finding that mean hours of Irish and Afro-American men exceed those of both Irish and German women. Thus, while Afro-American and English women have the highest overall average of care hours, 4.5 and 3.29 respectively, Irish and Afro-American men provide the next highest average care hours, 3.19 and 2.88 respectively.

Other interesting and contrasting behavior is identified when we examine the relationship between mean care hours and marital status, insurance coverage, and family relationship for each ethnic group. For English ethnics only, married caregivers provide higher mean hours of care. Only German caregivers who provide services to Medicaid insured elderly spend more hours in caregiving than when the elderly are not covered by Medicaid. For English and Afro-Americans only, caregivers who provide services to privately insured elderly spend more hours in caregiving than when the elderly are otherwise insured. With the exception of German ethnics, immediate family members average greater hours than non-immediate family or friends.

In Figure 1, we are also able to identify distinguishable patterns of behavior among ethnic groups. In the regression analysis, activities of daily living (ADLs) were significant and positively related to care hours. In Figure 1, we find this positive association is generally consistent with the stratified data; as ADLs increase, mean care hours increase. Additionally, notice that the care hours and ADL relationships are at least bimodal for every ethnic group, with Afro-Americans' informal care hours reaching a peak prior to that of other ethnic groups. Furthermore, there is a tendency for Afro-Americans to rank either first or second in average care hours according to the ADLs of the elderly.

DISCUSSION

Most of what is known about either the determinants of caregiving or labor market decisions is based on analysis that is neither racially nor ethnically differentiated. This paper indicates that among ethnic caregivers who face the joint decisions of the number of caregiving hours and whether to reduce labor hours or not, production factors, access to financial resources and personal characteristics of caregivers are significant determinants of both decisions. Specifically, in both regression models we found that the lower the health status of the elderly care recipient (more ADL limits) and/or the worse the health of the caregiver, the more likely the ethnic caregiver will increase caregiving hours and compensate by reducing labor market activities. On the other hand, if the caregiver has a substitute and/or lives with the care recipient, less informal care hours are provided and there is a lower probability that the caregiver will withdraw his/her skills from the labor market.

Recent federal policy initiatives have hastily sought to reduce the federal sector's obligations to provide care for the elderly by increasing the families' responsibilities for caregiving. The subsequent reduction in escalating inflation in health care expenditures by the Medicare program have been applauded. Yet, the magnitude of the reallocation of cost to

families has been ignored. According to the above empirical results, ethnic caregivers who service elderly with severe activity limits, have the worst health status, provide care without a substitute and do not live with the elderly, are more likely to bear the heaviest burden of this reallocation because they both provide more hours of informal care and lose labor market earnings. Consideration of this diversity in burden is an unfortunate omission of recent policy initiatives.

The general stability of the labor hours reduction equation is important to note. Whether we include the ethnic explanatory variables or not, production factors (ADL limits, substitutes, health status, children), financial resources (Medicaid coverage) and personal characteristics of the caregiver (marital status, living arrangements, sex) are key determinants of the number of hours allocated to the labor market. These findings differ from Muurinen's (1986) study of the labor market decisions of caregivers to hospice patients. In contrast to Muurinen's results, income, age and the relationship between the caregiver and the elderly were insignificant determinants of the labor market decision. The findings in the two studies may differ because (a) our regression model includes production factors and Muurinen's does not, or (b) we consider ethnic caregivers only. Thus the inclusion of these production factors, some correlated with socio-demographic factors, may cause the latter to be insignificant. Alternatively, ethnic caregivers may not be influenced by the same factors as the general population of caregivers. Patterns of mutual aid and responsibility to immediate and extended family may explain the insignificance of income and relationship in affecting labor market decisions. Further study of the role of production factors should prove useful for our understanding of the caregiver's circumstances, as well as, the unique role of socio-demographic characteristics.

Identifying the unique role of ethnicity is also essential as health care policy makers deliberate over the appropriate methods of intervening in the financing of home health services. Several alternative approaches are possible. Financial subsidies of caregivers, tax write-offs and providing greater insurance coverage of market-supplied home care through Medicare have all

been considered. This paper indicates that if the goal of the policy is to reduce transition out of the labor market, ethnic diversity is an unnecessary consideration in the policy choice. Ethnic diversity serves as an intervening factor in the caregiving hours decision; this relationship was not found to exist in the labor market decision. On the other hand, if the goal is to reduce the caregiver's stress by providing greater access to substitute caregivers, then the policy may not impact on all ethnic groups equally. Specifically, this paper's results suggest that such a policy may successfully decrease the care hours of German, Irish and English ethnics and increase those of Afro-Americans.

As Jackson (1989) and Gibson (1989) suggest, stratification by ethnicity is informative. The high ranking of both Afro-American males and females in providing care hours, as well as the tendency of this ethnic group to provide relatively high hours of care, regardless of the disability level of the elderly (ADL needs), the caregiver's marital status, or an available substitute to share the burden, suggests a striking, culturally-based pattern of behavior.

Several research questions are generated. Dual labor force participation of spouses is the tradition in the Afro-American household. Do the observed patterns of extensive allocation of hours to caregiving by Afro-American men and women reflect the cultural disposition of those households to jointly share work and household responsibilities? What portion of the relatively higher care hours allocations of Afro-Americans are due to a unique tradition of "mutual aid" for this ethnic group and what portion is due to structural factors, eg., racial segregation of institutional, elder care facilities?

White ethnic groups can be expected and were indeed found in the preliminary analysis (Table 3 and Figure 1), to exhibit heterogeneous patterns of caregiving. The similarity in the behavior of Irish and Afro-American caregivers is partly explained by Woerher (1978). Both ethnic groups are found to have collateral families where egalitarian friendships between parents, siblings and extended kin are likely to exist. Thus, siblings and friends have a significant role in the informal care networks of Irish and Afro-American families. In contrast,

English and German families are more likely to be lineal, where parents have an authoritative relationship with their children.

Other distinguishing patterns between the ethnic groups are less clear. For example, the authors are not aware of a theoretical basis for explaining why living together leads only one ethnic group (English) to provide more hours of care than when they do not live with the elderly. Why Irish caregivers in excellent, good, fair or poor health provide the same average care hours, i.e., the health status and ability level of the caregiver does not matter, is also unclear.

This paper's analysis of the role of ethnic diversity is exploratory. A lack of sufficient data hampers the ability to apply more stringent assessment methodologies. Detailed national survey data of caregivers who are ethnicly distinguished is essential.

REFERENCES

Cantor, Majorie. 1983. "Strain Among Caregivers: A Study of the Experiences in the United States." The Gerontologist 23: 597-604.

Gibson, Rose. 1989. "Minority Aging Research: Opportunity and Challenge." The Journals of Gerontology 44 (1): S2-S3.

Jackson, James. 1989. "Race, Ethnicity, and Psychological Theory and Research." The Journals of Gerontology 44 (1): P1-P2.

McCallum, John and Bruce Shadbolt. 1989. "Ethnicity and Stress Among Older Australians." The Journals of Gerontology 44 (3): S89-S96.

Mindel, Charles, Robert Haberstein and Roosevelt Wright. 1988. Ethnic Families in America. New York: Elsevier Scientific Publishing Company.

Muurinen, Jaana-Marja. 1986. "The Economics of Informal Care." Medical Care 24:1007-1017.

Pauly, Mark. 1990. "The Rational Nonpurchase of Long-Term Care Insurance." Journal of Political Economy 98 (1):153-168.

Shanas, Ethel. 1979. "The Family as a Social Support System in Old Age." The Gerontologist 19:169-174.

Stone, Robyn, Gail Cafferata and Judith Sangl. 1986. "Caregivers of the Frail Elderly: A National Profile." National Center for Health Services Research, Research Report.

White-Means, Shelley and Michael Thornton. 1989. "Ethnic Differences in the Production of Informal Home Health Care." (Working Paper).

Table 1: Independent Variables and Variable Measurement

Variable Name	Variable Measure
Production Variables	
ADL	# limits in daily activities, including walking, dressing, eating
IADL	# limits in instrumental activities
Substitutes	= 1 if respondent answers yes to the question, "If you are not available to help, is there someone who would do the things that you do?"
Number of Caregivers	# usual caregivers (includes family members, friends and other nonrelatives)
Health Perception	self perception of health
Education	highest grade attended in school
Children	# children < = 18
Income and Price of Home Health Care	
Family Income	income (before taxes) of all household members
Medicaid	= 1 if Medicaid Insured
Private	= 1 if Privately Insured
Preference Shifters	
Ethnicity	German, English, Irish, Afro-American
Age	continuous measure
Sex	= 1 if male
Marital Status	= 1 if married
Education	years of formal schooling
Living Arrangement	= 1 if live with impaired elderly
Immediate	= 1 if immediate family member

Table 2: Determinants of Caregiving Hours and Leisure Reduction

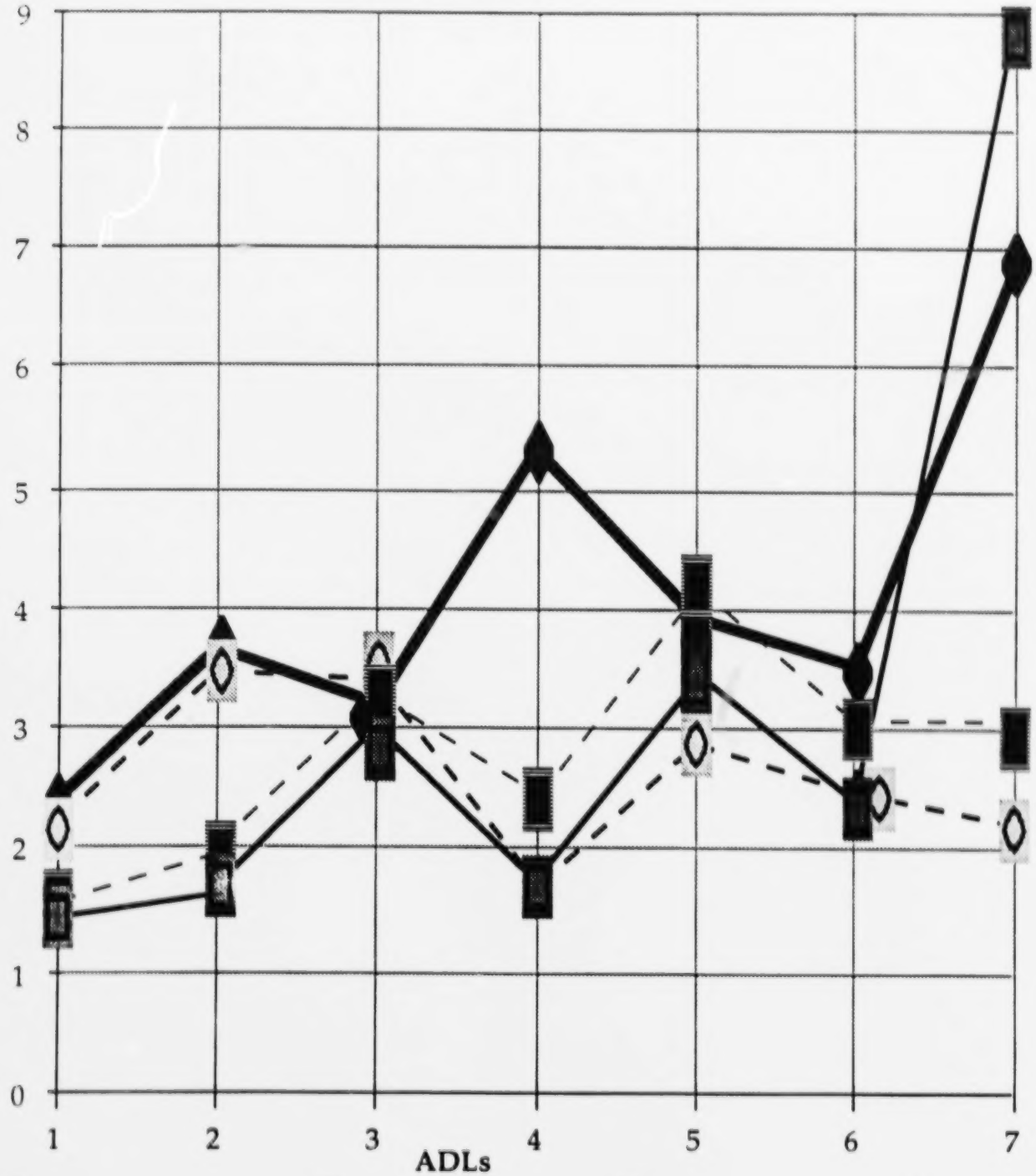
	Model I		Model II	
	Care Hrs. (t)	Labor Red. (X^2)	Care Hrs. (t)	Labor Red. (X^2)
Production Variables (E_{HC}, E_{HP})				
ADL	0.054	0.222	0.051	0.222
	(2.16)[b]	(5.89)[b]	(2.06)[b]	(5.84)[b]
IADL	0.043	-0.063	0.043	-0.059
	(1.62)	(0.46)	(1.65)[c]	(0.40)
Substitutes	-0.307	-0.621	-0.341	-0.622
	(-2.99)[a]	(3.09)[c]	(-3.39)[a]	(3.06)[c]
Number of Caregivers	0.022	-0.066	0.009	-0.059
	(0.58)	(0.26)	(0.24)	(0.20)
Health Perception				
= 1 if good	0.081	0.955	0.105	0.935
	(0.74)	(5.33)[b]	(0.98)	(5.10)[b]
= 1 if fair or poor	0.289	1.192	0.281	1.224
	(2.22)[b]	(6.65)[a]	(2.21)[b]	(6.94)[a]
Children	0.244	1.522	0.267	1.530
	(1.58)	(5.90)[b]	(1.76)[c]	(5.89)[b]
Income and Prices of Home Health Care				
Family Income	-0.040	-0.045	-0.028	-0.055
	(-2.27)[b]	(0.56)	(-1.62)	(0.79)
Medicaid	-0.067	0.759	-0.071	0.792
	(-0.56)	(3.56)[c]	(-0.60)	(3.67)[c]
Private	-0.049	0.476	0.015	0.424
	(-0.48)	(1.77)	(0.15)	(1.31)
Preference Shifters				
Ethnicity				
German			-0.377	0.488
			(-2.87)[a]	(1.10)
Irish			-0.341	0.229
			(-2.63)[a]	(0.23)
English			-0.437	0.058
			(-3.21)[a]	(0.01)
Age	-0.052	-0.101	-0.068	-0.094
	(-1.24)	(0.45)	(-1.63)	(0.38)
Sex	-0.160	-0.884	-0.141	-0.890
	(-1.48)	(4.78)[b]	(-1.33)	(4.68)[b]
Marital Status	-0.201	0.683	-0.151	0.662
	(-1.87)[c]	(3.19)[c]	(-1.43)	(2.94)[c]
Education	0.001	-0.047	0.007	-0.049
	(0.18)	(0.44)	(0.33)	(0.46)
Living Arrangement	-0.432	-0.731	-0.437	-0.717
	(-3.99)[a]	(3.76)[b]	(-4.10)[a]	(3.51)[b]
Immediate	0.025	0.300	0.072	0.280
	(0.22)	(0.53)	(0.64)	(0.47)
N	231	231	231	231
F	4.081[a]		4.31[a]	
X^2		45.61[a]		46.91[a]
R^2	0.18	0.21	0.21	0.18

a, $p < .01$ b, $p < .05$ c, $p < .10$

Table 3: Mean Caregiving Hours By Select Variables and Ethnicity

	Ethnic Group			
	German	Irish	English	Afro
	2.45	2.94	2.82	4.20
Variable				
Sex				
Female	2.83	2.84	3.29	4.50
Male	1.55	3.19	2.05	2.88
Marital Status				
Married	2.39	2.77	2.92	3.74
Not Married	2.61	3.38	2.72	4.63
Medicaid				
No	2.2	3.08	3.0	4.43
Yes	4.7	2.58	2.38	3.82
Private Insurance				
No	3.22	3.95	2.04	3.74
Yes	2.05	2.48	3.45	5.14
Immediate Family				
No	2.67	1.94	1.0	4.03
Yes	2.37	3.24	3.27	4.29
Live With				
No	2.96	3.35	2.81	4.47
Yes	2.12	2.56	2.87	4.00
Poor Health				
No	2.22	2.94	2.45	3.7
Yes	3.89	2.94	4.00	5.4
Substitute				
No	2.87	3.25	3.84	4.05
Yes	2.06	2.61	1.52	4.32

Mean Caregiving Hours Among Ethnics According to ADLs



English		Irish		German		Black	
1. 1.45	5. 3.44	1. 1.60	5. 4.20	1. 2.20	5. 2.90	1. 2.40	5. 3.90
2. 1.70	6. 2.36	2. 2.00	6. 3.05	2. 3.50	6. 2.47	2. 3.70	6. 3.50
3. 3.02	7.	3. 3.30	7.	3. 3.40	7.	3. 3.20	7.
4. 1.75	8.80	4. 2.45	3.00	4. 1.70	2.20	4. 5.33	6.90